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March 5, 2015

TO: PATRICK OGAWA
Acting Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: PATRICK A. WU
Senior Assistant County Counsel
Executive Office

RE: **Item for the Board of Supervisors' Agenda**
County Claims Board Recommendation
Aurora Navarrete, et al. v. County of Los Angeles
Los Angeles Superior Court Case No. BC 565 226

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and the Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

PAW:cs

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Aurora Navarrete, et al. v. County of Los Angeles, Los Angeles Superior Court Case No. BC 565 226, in the amount of $425,000 and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Fire Department's budget.

This wrongful death lawsuit alleges that Fire Department paramedics' inadequate management of Plaintiffs' spouse and father contributed to his prolonged hospitalization and his death.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Aurora Navarrete, et al. County of Los Angeles
CASE NUMBER	BC 565226
COURT	Los Angeles Superior Court
DATE FILED	December 3, 2014
COUNTY DEPARTMENT	Los Angeles County Fire Department
PROPOSED SETTLEMENT AMOUNT	$425,000
ATTORNEY FOR PLAINTIFF	Matthew Nezhad, Esq. Nezhad Shayesteh & Levy
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian Senior Deputy County Counsel
NATURE OF CASE	On September 7, 2013, Reynaldo Salas, a 51-year-old male, had a fall at home. A 911 call was made, and the Los Angeles County paramedics were dispatched. The paramedics examined Mr. Salas and arranged for him to be transported to a hospital. Later, it was determined that Mr. Salas had suffered from a neck injury. Mr. Salas remained at a hospital; he died on December 2, 2013 primarily as a result of his advanced liver disease. Mr. Salas' family brought a wrongful death case against the County of Los Angeles alleging that the paramedics' inadequate management of Mr. Salas' neck injury contributed to his prolonged hospitalization and his death.
PAID ATTORNEY FEES, TO DATE	None
PAID COSTS, TO DATE	$5,951

Case Name: Salas v. COLA

Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

Date of incident/event:	September 7, 2013
Briefly provide a description of the incident/event:	On September 7, 2013, a 911 call was placed by Mr. Salas' daughter from his Pomona residence requesting paramedics. Within one and a half minutes of the call the Fire Department dispatched paramedics while his daughters continued talking to the dispatcher. Although nothing in the call suggested that he had lost consciousness, the call was listed as "unconscious patient" when the call was transmitted to the responding units. During the call, and while the paramedics were in route, one of Salas' daughters reported that he was suffering from neck pain. Dispatch did not relay that information to the paramedics. Upon arrival, the paramedics examined Mr. Salas. He was awake and intoxicated but able to move his extremities. The paramedics found him sitting on his bed and holding a beer in his hand. The family stated that Mr. Salas had fallen from his mattress, which was on the floor, onto the carpeted floor. The family also reported that Mr. Salas had a history of a stroke, alcoholism and liver disease. The Emergency Medical Services ("EMS") form completed by the paramedics at the scene documents that Mr. Salas suffered trauma from a fall and was under the influence of alcohol. According to the Fire Department's policy and guidelines in effect at the time, the paramedics were required to place a cervical-spine collar ("c-collar") on Mr. Salas to immobilize his neck and place him on a back board to restrict his spinal cord movement. They failed to place him in a c-spine collar and on a back board. Mr. Salas was taken to Chino Valley Medical Center by a private ambulance. When he arrived, he was unable to move his extremities. An imaging study of the cervical spine showed that he had a subluxation or displacement of the cervical vertebrae and spinal cord bruising. These injuries progressed and led to permanent injury to the spinal cord resulting in quadriplegia. After one day at Chino Valley Medical Center Mr. Salas was transferred to Arrowhead Regional Medical Center. While there he underwent surgery but his condition gradually deteriorated, and he died at that facility on December 2, 2013. No autopsy was performed. Although the death certificate, completed by Arrowhead Regional Medical Center

	staff, states the primary cause of death was liver disease and chronic alcoholism, the County's medical consultant believes that Mr. Salas' paralysis and prolonged immobility contributed to his death.

1. Briefly describe the **root cause(s)** of the claim/lawsuit:

- Failure of a Captain to manage an emergency scene and ensure proper assessment and treatment of a patient and omitting information on an EMS form.
- Failure to ensure proper assessment and treatment of a patient by implementing spinal immobilization precautions.
- The 911 Call Taker needing to select the most significant call type, when presented with multiple medical complaints, and determine what is the relevant medical information to be transmitted to the responding units within the Department goal of one minute from receipt of the call to transfer to dispatch.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

1. The Captain in charge of this response received a 30 day suspension for failure to properly manage an emergency scene and ensure adequate assessment and treatment of a patient and for omitting information on an EMS report. The letter of intent to suspend has been served on the employee. The employee is exercising his administrative appeal rights. The LEMSA has placed the Captain's EMT Certification on probation for one year. – September 2, 2014 - Acting Deputy Chief East Region Operations Bureau
2. The Firefighter Specialist received a six day suspension for failure to properly asses and treat a patient by not implementing spinal immobilization procedures and violating the Department policy on documentation. The letter of intent to suspend has been served on the employee. The employee is exercising his administrative appeal rights. The LEMSA has placed the Firefighter Specialist's EMT Certification on probation for one year. – September 2, 2014 - Deputy Chief North Region Operations Bureau
3. The Firefighter received a six day suspension for failure to properly asses and treat a patient by not implementing spinal immobilization procedures. The letter of intent to suspend has been served on the employee. The employee is exercising his administrative appeal rights. The LEMSA has placed the Firefighter's EMT Certificate on probation for one year. – September 2, 2014 - Acting Deputy Chief East Region Operations Bureau
4. The Captain was provided directed education and case review to ensure that he is confident in his ability to assess and treat a similar patient in similar circumstances going forward. – September 2013 – Medical Director
5. The Firefighter Specialist was provided directed education and case review to ensure that he is confident in his ability to assess and treat a similar patient in similar circumstances going forward. – September 2013 – Medical Director
6. The Firefighter was provided directed education and case review to ensure that he is confident in his ability to assess and treat a similar patient in similar circumstances going forward... – September 2013 – Medical Director
7. The dispatcher who took the call from the family members received a Notice of Instruction reminding him to use proper call typing procedures on all calls. – December 11, 2014 – Assistant Fire Chief Command & Control
8. All dispatchers will be provided training on a review of call typing as part of their regular monthly training. – January 31, 2015 – Assistant Fire Chief Command & Control

9. All paramedics were required to attend EMS Update 2014 which incorporated the new algorithm to evaluate the need for Spinal Motion Restriction. All EMT's were introduced to the new Spinal Motion Restriction algorithm and rationale for assessing the need for SMR – May 2014 to September 2014 – Acting Deputy Chief EMS Bureau

3. Are the corrective actions addressing department-wide system issues?

☒ Yes – The corrective actions address department-wide system issues.

☐ No – The corrective actions are only applicable to the affected parties.

Name: (Risk Management Coordinator) Michael Kranther, Division Chief	
Signature: Michael Kranther	Date: 2/5/15

Name: (Department Head) Daryl L. Osby, Fire Chief	
Signature: Daryl Osby	Date: 02/05/15

Chief Executive Office Risk Management Inspector General USE ONLY

Are the corrective actions applicable to other departments within the County?

☐ Yes, the corrective actions potentially have County-wide applicability.

☒ No, the corrective actions are applicable only to this department.

Name: (Risk Management Inspector General) Destiny Castro	
Signature: Destiny Castro	Date: 2/5/2015